OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Iowa_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Kevin W. Concannon	Position/Title: Director, Iowa Department of Human Services
Name: Ann Wiebers	Position/Title: Administrator, Division of Financial, Health and Work Supports
Name: Anita Smith	Position/Title: Bureau Chief, Bureau of Medical Supports

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70):**

1.1.1 Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. X A combination of both of the above.

Medicaid Expansion (M-CHIP)

Effective July 1, 1998

- Children ages 15 through 18 in families with income between 37 percent and 100 percent of Federal Poverty Level (FPL). These are the "Waxman" children that are being phased-in to Medicaid as a mandatory coverage group. Beginning October 1, 2002, all of these children will be covered under Medicaid.
- Children ages 6 through 18 in families with income that is equal to or less than 133 percent of FPL.

Effective July 1, 2000

- Infants, up to one year of age, in families with income between 185 percent and 200 percent of FPL.

The State has implemented systems changes that allow for identification of children eligible for Medicaid via CHIP so they can be reported separately from children eligible for Medicaid via the 1902(r)(2) Medicaid State Plan Amendment. This will allow CHIP eligible children (optional targeted low-income children) to be reported and claimed at the enhanced rate and other newly eligible children to be reported and claimed at the State's standard FMAP.

Children eligible for Medicaid as a result of the expansion receive health care services through the same delivery systems that operate in the Medicaid program.

Separate Program: Healthy And Well Kids In Iowa (***hawk-i***) Program (S-CHIP)

The Healthy And Well Kids in Iowa (***hawk-i***) program covers targeted low-income children up to age 19 in families who income does not exceed 200% of the FPL.

Effective January 1, 1999, the State implemented the ***hawk-i*** program for targeted low-income children up to age 19 in families who income was at or below 185% of the federal poverty level (FPL). The State expanded coverage to 200% of the FPL effective July 1, 2000.

The ***hawk-i*** program has several components and is designed to encompass a variety of entry points into the program. The delivery of services follows a private sector commercial insurance model.

Iowa Department of Human Services: The Department of Human Services (DHS) has been designated as the State agency to administer the ***hawk-i*** program.

hawk-i Board. The Iowa General Assembly authorized the creation of the ***hawk-i*** Board to provide direction to the Department of Human Services and to establish policy for the program. The ***hawk-i*** Board is made up of eleven members:

- Director of the Iowa Department of Public Health or their designee
- Director of the Iowa Department of Education or their designee
- Commissioner of the Iowa Division of Insurance or their designee
- Four Governor-appointed public members
- Four ex-officio legislators (2 Senate/2 House of Representatives)

Third Party Administrator: The Department of Human Services has contracted with a third party administrator to provide, at a minimum, the following services:

- Distribute applications
- Determine eligibility
- Screen for Medicaid eligibility and coordinate with co-located Medicaid eligibility workers.
- Calculate, bill, and collect cost sharing.
- Assist the family in selecting a health plan and enrolling the child in the selected plan.
- Gather encounter data from the health plans.
- Provide DHS with demographic, statistical, and encounter data for federal reporting and other reporting requirements.

Advisory Committees: Two advisory committees have been established to provide input to the ***hawk-i*** Board. The Clinical Advisory Committee is made up of health care professionals who advise the ***hawk-i*** Board on issues around benefits, access, and quality. The Children With Special Health Care Needs Advisory Committee is made up of health care professionals and advocates who advise the ***hawk-i*** Board on health

care issues faced by children with special needs and make recommendations on how to address those needs.

Health and Dental Plans: The Department of Human Services contracts with health and dental plans licensed by the Division of Insurance within the Department of Commerce to provide health and dental care coverage to eligible children under the ***hawk-i*** program.

The University of Iowa Public Policy Center: The Department of Human Services contracts with the University of Iowa Public Policy Center to conduct analysis of the functional health assessment and analysis of the encounter data. Effective July 1, 2005, the Department of Human Services will contract with the Iowa Foundation for Medical Care to conduct the analysis of the functional health assessment and analysis of the encounter data.

1.2 X Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 **X** Please provide an assurance that the state complies with all applicable civil rights requirements, including Title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date: SCHIP State Plan- Medicaid Expansion 5-1-1998
Amendment 7 - Expansion of counties for Iowa Health Solutions 6-1-2003 and elimination of 6-month waiting period 7-1-2003.

Amendment 8 – Electronic Medicaid referral process 7-1-04, adding dental only plans 01-01-05, and withdrawal of Iowa Health Solutions 2-1-05

Amendment 9 – Expansion of counties for John Deere and Delta Dental 3-1-06

Implementation date:
Amendment 7 - Expansion of counties for Iowa Health Solutions 6-1-2003 and elimination of 6-month waiting period 7-1-2003

Amendment 8 – Electronic Medicaid referral process 7-1-04, adding dental only plans 01-01-05, and withdrawal of Iowa Health Solutions 2-1-05

Amendment 9 – Expansion of counties for John Deere and Delta Dental, 3-1-06

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination **(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))**

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

Historically, Iowa is a rural, agricultural state. However, recently there has been a shift in population from rural areas to urban centers. New estimates from the U.S. Census Bureau show that population growth in Iowa during the 1990's is confined to two areas: in and around Des Moines, and in the Cedar Rapids/Iowa City corridor. At the same time, 45 of Iowa's 99 counties are losing population. Data from 1994 suggests that 44 percent of Iowans live inside a metropolitan area.

According to the 2000 U.S. Census, Iowa has a population of 2,926,324 with 23.8% (827,983) being children ages 19 and younger. The Census reports show 11.5% of Iowa's population or 336,527 people living below poverty. In general, the highest levels of poverty are in the southern counties along the Missouri border.

While approximately 2,747,818 (93.9%) of Iowa's population are white and 61,423 (2.3%) are black, Iowa is experiencing an ever-emerging diverse population. For Iowa's children ages 19 years and younger, the percentages of different races varies from the total population. The children are 90.9% white, 3% black or African American, 0.4% American Indian or Alaska Native, 2% are of other race and 2.2% are two or more races. There are 36,263 Hispanic children (can be of any race) in Iowa.

Additionally, Iowa is becoming home to more and more refugees from all areas of the world. Most recently, Iowa has had significant numbers of Sudanese and Bosnians settle in some of the larger urban centers of the State.

Estimate Number of Refugees and Amerasians in Iowa

Region of Origin	Number Who Originally Settled in Iowa
Africa	
Sudanese	773
All other ethnicities	719
Near East	
Iraqi	144
All Others	99
Former Soviet Union	
All ethnicities	443
Eastern Europe	
Bosnian	4,611
Kosovar	185
All other ethnicities	361
Southeast Asia	
Vietnamese	7,383
Tai Dam	2,740
Lowland Lao	3,281
Cambodian/Khmer	840
Hmong	423
Latin America/Caribbean	
Haitian	32
All other ethnicities	5
TOTAL	**21,988**

The Mesquaki Tribe is the only Federally recognized Native American Tribe in Iowa. It is a subset of the Sac and Fox of the Mississippi and Iowa Tribe and currently has 1,277 enrolled members. The improving economic conditions on the Mesquaki Settlement, primarily due to casino revenue, have resulted in a significant growth trend and 200% birth rate increase since 1992. According to the 2000 U.S. Census, 8,989 people identified themselves as Native American or Alaska Native. Of this number 39.1% are 19 years of age or younger.

The only public health insurance program generally available in Iowa is Medicaid. In April 2002, there were 129,192 children (66,369 male/ 62,823 female) receiving coverage through the Medicaid program.

The Iowa Caring Program for Children, a primarily privately funded, Wellmark (Blue Cross Blue Shield of Iowa and South Dakota) sponsored program, covered about 3,000 children below 133% of FPL. This program covered uninsured children who

did not qualify for Medicaid. With the expansion of Medicaid and implementation of the ***hawk-i*** program, the Caring Program ceased their program operations on July 1, 1999.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Medicaid

The Medicaid program is the only public health insurance program for children in Iowa. Medicaid is administered through the Department of Human Services (DHS) Central Office in Des Moines and through 104 DHS offices (including the Refugee Services Center) located in all 99 counties. Additionally, outstationed eligibility workers are currently located at Broadlawns Hospital in Des Moines. The University of Iowa in Iowa City has 6 intake positions.

There are five Federally Qualified Health Centers (FQHC) in Iowa. Currently there is one outstationed eligibility worker position at each of these sites.

Medicaid applications are readily available to anyone who requests one. Additionally, there is a toll-free number for anyone to call and ask questions about Medicaid eligibility and to find how to apply. The number is 1-800-869-6334.

In April 2000, Iowa had 129,192 children with health care coverage through the Medicaid program. Eligibility for Medicaid continues to remain available for the following federal categories of children. Those who qualify because they would have been eligible for cash assistance prior to July 16, 1996, and related categorical programs; those who are in foster care and subsidized adoption; those who qualify for the Mothers and Children program (SOBRA); those who meet disability criteria; those who are medically needy, and those who qualify under the following home and community based waivers:

	Enrollment Cap
♦ Ill and Handicapped Waiver	1660
♦ Mental Retardation Waiver	2348(for children) + 100 ICF/MR beds
♦ Brain Injury Waiver	372
♦ AIDS Waiver	50
♦ Physical Disability Waiver	144
♦ Elderly Waiver	Dependent on number of clients enrolled and amount of reimbursement for clients

Health Insurance Premium Payment Program (HIPP)

Iowa was one of the first states to implement the provisions of section 1906 of the Social Security Act which mandated states to purchase employer-related health insurance coverage for Medicaid-eligible persons when it was determined cost-effective to do so. Iowa implemented the Health Insurance Premium Payment (HIPP) program on July 1, 1991. Although section 1906 of the Social Security Act has now become optional, Iowa continues to maintain a strong HIPP program. Although this program is primarily designed to reduce Medicaid expenditures by providing a third party resource for Medicaid-eligible persons, oftentimes it is cost-effective to purchase family coverage which results in providing coverage for the non-Medicaid eligible household members as well. By initiating coverage while on Medicaid, families have coverage in place when they leave the Medicaid roles.

Direct Health Services (Title V, Title X, WIC, etc.)

The Iowa Department of Public Health (IDPH) is the largest single provider of direct as well as support patient care for uninsured and Medicaid enrolled children and adolescents. Direct services for this population include: preventive child health services (EPSDT) and well-child check-ups, prenatal services, Women, Infants and Children Supplemental Nutrition (WIC) program services, preventive health education, immunizations, and family planning services. Support services include case coordination services, the provision of information and referral via toll-free telephone lines, and laboratory services. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family programming funds, federal WIC Program funds, Medicaid program reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue collected on a sliding fee scale by Title V agencies. A variety of the above direct and support services are provided within each of the 99 Iowa counties. Twenty-six Maternal Health Centers and twenty Child Health Centers provide statewide services. Adolescent services are provided in 25 locations in the state.

Additionally, there are approximately 486 full-time school health nurses working under the auspices of the Iowa Department of Education and local education agencies in the state who provide a variety of health screening services, care coordination and emergency services.

Income assessments are performed on patients enrolled in IDPH clinics. The income assessments are reviewed for possible Medicaid eligibility. New applications, as well as annual reviews of established patients, are assessed by

IDPH intake staff and/or care coordinators for possible referral for medical assistance through Medicaid and/or SSI.

In order to provide additional outreach, The IDPH operates two toll-free telephone lines for use by the general public. The toll-free telephone lines are known as Healthy Families and Teen Line. These are information and referral services for health issues. The Healthy Families line addresses a wide variety of health issues with emphasis on prenatal care. The Teen Line also addresses a variety of issues specifically related to the health of teenagers. Topics covered include drugs, sexual relationships, eating disorders, relationships with parents, and violence. Two integral parts of the information provided to callers, via these telephone lines, are information on Medicaid eligibility and referrals to community based care coordinators who can assist clients with locating local health providers who accept Medicaid-eligible children and Medicaid-eligible pregnant women. The toll-free number for Health Families is 1-800-369-2229. The Teen Line number is 1-800-443-8336. Both lines are operational 24 hours a day, seven (7) days a week.

Child Health Specialty Clinics

Each year, approximately 5,500 Iowa children receive services at the Child Health Specialty Clinics (CHSC). The Department of Human Services has an interagency cooperation agreement with the CHSC which serve as a link between major medical centers and the community by assisting families to obtain needed resources. The CHSC serves children from birth to 22 years with or at risk of a chronic health condition or disability, which includes psychosocial, physical, health-related educational, and behavioral needs. The specific health concerns may be simple or complex, short-term or long-term.

Small Group Insurance Reform

Iowa enacted small group reforms in 1992. These reforms provided more affordable coverage for the small group market, thus allowing employees and their dependents to obtain coverage at more affordable rates. The reforms included limitations on rate increases as well as limitations on pre-existing condition clauses.

In 1996, Iowa implemented individual market reforms which provide for portability for employees and their dependents form a group to the individual market, as well as rating restrictions on individual products.

State High Risk Insurance Pool

Iowa law established a state administered high-risk health insurance program for those individuals and their dependents who cannot obtain coverage in the

private market. This program is funded by a 2% tax on health insurance premiums. Persons who are eligible for Medicaid or COBRA continuation coverage are not eligible to participate in this program. Coverage in the high-risk program provides for individuals to the private market.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Currently there are no health insurance programs that involve a public-private relationship.

The Caring Program for Children

There was one health insurance program in Iowa that resembled a public-private partnership. However, it was not administered by the State. This program was known as the Caring Program for Children and was administered by Wellmark (Blue Cross and Blue Shield of Iowa and South Dakota). The Iowa Caring Foundation provided ambulatory health insurance to low income, non-Medicaid/uninsured children under the age of 19 years who remain full-time students through grade 12. During its 10 years of operation, the Caring Foundation was funded through a state appropriation and private donations, with matching funds from Wellmark. At its peak the Caring Program had an enrollment of over 3000 children. The Caring Program ceased operation on June 30, 1999.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as Title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

At the time a child is determined not to be eligible for ***hawk-i***, the letter the applicant receives states: "Although you child does not qualify for ***hawk-i***, health care services may be available through your local child health agency. For information about the child health center in your area, please call 1-800-369-2229 (Iowa Healthy Families Information and Referral Service)."

When it is determined that a child does not qualify or will no longer qualify for Medicaid due to excess income, a referral is made to ***hawk-i***. The referral can be accomplished either electronically or using a paper form. In either format, the referral includes the name of the child (or children), the Medicaid application date (for children denied Medicaid) or the Medicaid end date (for children cancelled from Medicaid), and the reason for the referral. The electronic referral also includes the income amounts used to determine Medicaid ineligibility. A copy of the Medicaid

notice of decision denying or cancelling Medicaid accompanies the paper referral. This notice contains a calculation showing how Medicaid ineligibility due to excess income was determined.

The third party administrator performs a comparison of ***hawk-i*** enrollees to Medicaid enrollees. A file containing the Medicaid enrollees is received and matched daily with the ***hawk-i*** enrollee file. If a match is found, the child is cancelled from ***hawk-i*** after being given notice of the cancellation.

If a individual applying for health services through a public health clinic also wishes to apply for Medicaid or ***hawk-i***, the public health clinic will forward this information to ***hawk-i*** within two working days.

If an individual applying for WIC services also wishes to apply for Medicaid, the WIC agency will forward the information to Medicaid. If an individual applying for WIC appears to qualify for ***hawk-i***, the individual is given a ***hawk-i*** enrollment form.

If a child applying for ***hawk-i*** is determined to be eligible for Medicaid, a referral for EPSDT is made. If a child or family asks about WIC, a WIC brochure along with the location of the nearest WIC is given to them .

In the action plans of the Title V agencies in Iowa, the Title V agencies have included outreach to ***hawk-i*** and Medicaid to children who may be eligible. The agencies will identify these children, notify the families of the program and advise them where and how to enroll and how to maintain the enrollment.

The Iowa Department of Human Services will be entering into a contract with the Iowa Department of Public Health to conduct grassroots outreach for the ***hawk-i*** and Medicaid programs. The Iowa Department of Public Health who oversees the Title V agencies, will ask the Title V agencies to either conduct the grassroots outreach activities or to subcontract with an agency or organization to do outreach. The Title V agencies will be responsible for doing a gap analysis to see what community agencies are currently doing for outreach as well as determine what is missing. The action plans must include the results of the gap analysis and what steps the agency will take to involve the community in conducting outreach.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

Healthy And Well Kids in Iowa (***hawk-i***) Program

The State has entered into contractual agreements with commercial insurers to provide a benchmark equivalent benefit package to enrollees in the ***hawk-i*** program. The insurer will provide the enrollee with a health plan card identifying them as an enrollee in that health plan. The enrollee will have a primary care physician if they are in a managed care plan.

Both indemnity and managed care plans are allowed to participate in the program. The goal is to allow choice among plans so that enrollees can select the health plan from which they want to receive coverage. Both indemnity and managed care plans receive a monthly capitation payment for each ***hawk-i*** enrollee in the plan. The State contracts with indemnity plans only in those counties where the State does not have a contract with a managed care plan. If the State enters into a contract with a managed care plan in a county where the State currently has a contract with an indemnity plan, the ***hawk-i*** enrollees of the indemnity plan shall remain enrolled with the indemnity plan until the expiration of the twelve-month enrollment. All enrollees eligible for the ***hawk-i*** program after the execution of the contract with the managed care plan shall be enrolled with the managed care plan.

Effective July 1, 2003, the Iowa legislature passed legislation that allows dental only carriers to participate in the ***hawk-i*** program. Effective 01-01-05, in the counties that have a managed care plan, a ***hawk-i*** enrollee may choose to receive dental coverage through the chosen health plan or through a separate dental plan. The State contracts with the dental plan to provide dental only services and the dental plan receives a capitation payment for each ***hawk-i*** enrollee in the plan.

A child shall remain enrolled in a health and dental plan for a twelve-month period unless there is a substantial change in the provider network of the health or dental plan originally chosen. A substantial change is determined by the ***hawk-i*** Board and means, but is not limited to, loss of a contracted hospital or provider group. When there is another participating health or dental plan available in the child's county of residence, the child may disenroll from the current health or dental plan and enroll in the other health or dental plan for the remainder of the twelve-month period.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Healthy And Well Kids in Iowa (*hawk-i*) Program

Health and dental plans are allowed to establish limits for services and implement utilization management guidelines such as requiring prior authorization and using drug formularies as long as the plan provides the required services and meets benchmark equivalency. Plans may not deny coverage due to the existence of a pre-existing medical condition.

The State conducts periodic evaluations of each health plan for the purpose of reviewing the policies and procedures for utilization management, appeals and grievances, contract compliance, health education programs and materials, and the quality improvement program

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. X Geographic area served by the Plan: The State has been divided into six regions for the purpose of establishing plan participation (See Attachment 1). If a health plan wants to provide coverage in any county within a region, it must provide coverage in every county within that region in which it licensed and has a provider network established. Under ***hawk-i***, managed care plans can only provide coverage in those areas of the state in which they are licensed and in which a provider network is established.

Effective March 1, 2006:

John Deere Health Plan is providing health care coverage only in the following Iowa counties:

Appanoose	Clayton	Guthrie	Lee	Polk
Black Hawk	Clinton	Iowa	Linn	Poweshiek
Benton	Dallas	Jackson	Louisa	Scott
Boone	Davis	Jasper	Lucas	Story
Bremer	Delaware	Jefferson	Madison	Warren
Buchanan	Dubuque	Johnson	Marion	Van Buren
Butler	Greene	Jones	Monroe	Wapello
Cedar	Grundy	Keokuk	Muscatine	Washington

Effective March 1, 2006

Delta Dental of Iowa is providing dental only coverage in the following Iowa counties:

Appanoose	Clayton	Guthrie	Lee	Polk
Black Hawk	Clinton	Iowa	Linn	Poweshiek
Benton	Dallas	Jackson	Louisa	Scott
Boone	Davis	Jasper	Lucas	Story
Bremer	Delaware	Jefferson	Madison	Warren
Buchanan	Dubuque	Johnson	Marion	Van Buren
Butler	Greene	Jones	Monroe	Wapello
Cedar	Grundy	Keokuk	Muscatine	Washington

Effective February 1, 2005:

Classic Blue (Wellmark Blue Cross Blue Shield of Iowa) is providing coverage in the following Iowa counties:

Adair	Clay	Hardin	Monona	Sioux
Adams	Crawford	Harrison	Montgomery	Tama
Allamakee	Decatur	Henry	Page	Taylor
Audubon	Des Moines	Howard	Palo Alto	Union
Buena Vista	Dickinson	Humboldt	Plymouth	Wayne
Calhoun	Emmett	Ida	Pocahontas	Webster
Carroll	Fayette	Kossuth	Pottawattamie	Winnebago
Cass	Floyd	Lyon	O'Brien	Winneshiek
Cerro Gordo	Franklin	Mahaska	Osceola	Woodbury
Cherokee	Fremont	Marshall	Ringgold	Worth
Chickasaw	Hancock	Mills	Sac	Wright
Clarke	Hamilton	Mitchell	Shelby	

Effective March 1, 2006:

Classic Blue (Wellmark Blue Cross Blue Shield of Iowa) is not accepting new enrollees in the following Iowa counties:

Appanoose	Davis	Jefferson	Lucas	Poweshiek
Boone	Greene	Keokuk	Marion	Story
Buchanan	Guthrie	Lee	Monroe	Van Buren
Clinton	Jasper	Louisa	Muscatine	Wapello

Effective February 1, 2005:

Iowa Health Solutions is no longer participating with the ***hawk-i*** program.

4.1.2. X Age: Under ***hawk-i***, children up to the age of 19 are covered. Coverage ends effective the first day of the month following the month of the nineteenth birthday.

4.1.3. X Income: Effective July 1, 2000, under ***hawk-i***, countable earned and gross unearned income cannot exceed 200% of the FPL for family of the same size. Effective December 1, 1999, 20% of earned income (including self-employment income) will be exempt when determining family income for the ***hawk-i*** program.

Effective February 1, 2000, income from self-employment: under ***hawk-i***, income from self-employment will be the gross income minus the cost of doing business. This includes the depreciation of capital assets as identified for income tax purposes.

4.1.4. Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. X Residency (so long as residency requirement is not based on length of time in state): Under ***hawk-i***, the child must be a resident of the State of Iowa. There is no minimum period of time in which the child must reside in the State to establish residency. A resident is one:

a. Who is living in Iowa voluntarily with the intention of making that person's home in Iowa and not for a temporary purpose; or
b. Who, at the time of application, is not receiving assistance from another state and entered Iowa with a job commitment or to seek employment or who is living with parents or guardians who entered Iowa with a job commitment or to seek employment.

4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. X Access to or coverage under other health coverage: A child who is covered under other health insurance is not eligible for coverage under ***hawk-i*** unless the coverage is a single service coverage such as a dental only or vision only policy. Access to coverage is not considered if the child is not actually covered.

4.1.8. X Duration of eligibility: Eligibility for ***hawk-i*** is granted in 12-month enrollment periods. At the end of the 12 months, a review is completed to establish eligibility for the next 12-month enrollment period.

4.1.9. X Other standards (identify and describe): Pregnancy. During the 12-month enrollment cycle, if a child enrolled in the ***hawk-i*** program becomes pregnant, Medicaid eligibility will be determined. If eligible, the pregnant child will be transferred to the Medicaid program. If Medicaid eligibility does not exist, eligibility will continue under ***hawk-i***.

Inmates of nonmedical public institution. At the time of application or annual review of eligibility, the child shall not be an inmate of a nonmedical public institution as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

Inmates of institutions for mental disease. At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental as defined at 42 CFR 435 Section 435.1009 as amended November 10, 1994.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. X These standards do not discriminate on the basis of diagnosis.
4.2.2. X Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. X These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

Initial Enrollment

Applications for the ***hawk-i*** program are received via mail, fax, or on-line through the ***hawk-i*** web site by the third party administrator at a central location in Des Moines, Iowa.

Applications are screened for completeness of information, the presence of other health insurance, verification of income, the presence of State of Iowa employment, and Medicaid eligibility. If it appears that child is Medicaid eligible, the original application is referred to a Medicaid eligibility worker co-located at the third party administrator's office for a Medicaid eligibility determination. (See Attachment 2)

Upon receipt of a completed application, the third party administrator must determine ***hawk-i*** eligibility within 10 working days. If it is determined the child is uninsured, that countable income is below the ***hawk-i*** limit, and that the child otherwise qualifies, a notice of approval is sent to the family. Included with the approval notice is information about the health plans available to the family and a Plan Selection form on which the family must make their selection. If countable income exceeds 150% of FPL, the family is also required to pay a premium of $10 per month per child, not to exceed $20 per month, regardless of family size. Cost sharing is not assessed to American Indian or Alaska Native children, regardless of income.

Upon receipt of the Plan Selection form and the premium (if applicable), the third party administrator notifies the health plan of the new enrollment. If the Plan Selection form is not returned by the due date, the third party administrator randomly assigns the family to a health plan. The family has thirty days to notify the third party administrator if they want to change the health plan. The health plan provides an identification card, an explanation of coverage, and a list of participating providers to the family.

Ongoing Eligibility During the 12-Month Enrollment

Once eligibility is established, the child shall remain enrolled in the ***hawk-i*** program for a 12-month enrollment period unless one of the following occurs:

a. The child moves to an area of the state not served by that plan. In which case, the child shall be enrolled in a participating plan in the new location. The enrollment period is the remaining months of the original 12-month enrollment.
b. Age. The child shall be disenrolled from the ***hawk-i*** program as of the first day of the month following the month of the nineteenth birthday.
c. Nonpayment of premiums. The child shall be disenrolled as of the first day of the month following the month in which premiums are not paid. If the family reports a decrease in income during the 12-month enrollment period, premium cost sharing is re-evaluated. If the family's income is reduced below 150 percent of FPL, the family will not have to pay a premium for the remaining months of the enrollment period.
d. Iowa residence is abandoned. The child shall be disenrolled from the plan and canceled from the program as of the first day of the month following the month in which the child relocated to another state.
e. Medicaid eligibility. The child shall be disenrolled from the plan and canceled from the program as of the first day of the month following the month in which Medicaid eligibility is attained.
f. Enrolled in other health insurance. The child shall be disenrolled from the plan as of the first day of the month following the month in which the child attains other health insurance coverage.
g. Admission to a nonmedical public institution. The child shall be disenrolled from the plan and canceled from the program as of the first day of the month in which the child enters a nonmedical public institution unless it can be established that the absence is temporary.
h. Employment with the State of Iowa. The child shall be disenrolled from the plan and canceled from the ***hawk-i*** program as of the first day of the month in which the child's parent becomes eligible to participate in a health plan available to State of Iowa employees.

Recertification

All eligibility factors are reviewed annually as follows:

a. Sixty (60) days prior to the end of the 12-month enrollment period, the third party administrator mail a ***hawk-i*** renewal application form to the family. The renewal application form is preprinted with the information known about the household. The family is asked to verify the correctness of the information and return the corrected form with current income verification. A postage-paid return envelope is provided.
b. If the family fails to return the information or required income verification, the child shall not be recertified for the next 12-month enrollment period.
c. Upon a determination that the child continues to meet all eligibility factors, the family shall be allowed to select another plan for the next 12-month enrollment period if another plan is available. If the family does not select another plan, the

child shall be re-enrolled with the current plan for the next 12-monthe enrollment period.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

Check here if this section does not apply to your state.

When the Department has established that all of the funds appropriated for this program are obligated, the third-party administrator shall deny all subsequent applications for ***hawk-i*** coverage unless Medicaid eligibility exists.

a. The third-party administrator shall mail a notice of decision. The notice shall state that:
(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or
(2) The person does not meet eligibility requirements. In which case, the applicant shall not be put on a waiting list.

b. Prior to an applicant's being denied or placed on the waiting list, the third-party administrator shall refer the application to the Medicaid program for an eligibility determination. If Medicaid eligibility exists, the department shall approve the child for Medicaid coverage in accordance with 441—86.4(514I).

c. The third-party administrator shall enter applicants on the waiting list on the basis of the date a completed Form 470-3564 is date-stamped by the third-party administrator. In the event that more than one application is received on the same day, the third-party administrator shall enter applicants on the waiting list on the basis of the day of the month of the oldest child's birthday, the lowest number being first on the list. The third-party administrator shall decide any subsequent ties by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, the third-party administrator shall select applicants from the waiting list based on the order in which their names appear on the list and shall notify them of their selection.

e. After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant's continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within 15 working days, the third-party administrator shall delete the applicant's name from the waiting list and shall contact the next applicant on the waiting list.

At the point it is known that Iowa will need to implement a waiting list, DHS will notify the ***hawk-i*** Board and CMS giving as much advance notice as possible. DHS will also notify issue a press release for public notice indicating when the waiting list will be implemented.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

Refer to response in 4.3.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

Refer to response in 4.3.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Refer to response in 4.3.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. X Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

A child who is currently enrolled in an individual or group health plan is not eligible to participate in the ***hawk-i*** program. **Exception:** A child who is enrolled in a single service plan that provides coverage only for a specific disease or service (e.g. dental only or vision only) is considered uninsured for the purpose of establishing ***hawk-i*** eligibility.

Effective July 1, 2003, the State no longer imposes a 6-month waiting period for children who have been insured through an employer group health plan in the six months prior to the month of application. Iowa House File 565 included provisions that require the Department to monitor the effects of eliminating the 6-month waiting period and report back to the General Assembly on the findings. The state is continuing to ask insurance history questions

on the application form and the information is being tracked by the state's third party administrator. A quarterly report will identify the impact of this change on the program and be reported to the General Assembly.

4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

American Indian and Alaska Native Children are eligible for the ***hawk-i*** program on the same basis as any other children in the State, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care. No premiums or other cost sharing apply to American Indian or Alaska Native children.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Grassroots Outreach

In July of 1999, the ***hawk-i*** Board directed the Iowa Department of Human Services to develop a grassroots outreach effort. The Department developed a plan by which communities would bring together those individuals and entities that touch the lives of families with children in order to develop a community outreach strategy. Once the plan was developed, it was submitted to the Department for approval and funding was made available to assist in the implementation plan. Currently, the Department has 53 community outreach contracts that cover 89 counties.

Covering Kids Grant Project:

Covering Kids is a 3-year grant that was awarded to the Iowa Department of Public Health in 1999 by the Robert Wood Johnson Foundation. The purpose of the grant is to increase access to health care coverage for all uninsured and underinsured children in Iowa. Administrators of the grant work collaboratively with the Iowa Department of Human Services, the Iowa Department of Education, advocates, medical providers, and others to address barriers to access for uninsured and underinsured children. This grant expires on June 30, 2002. As of July 1, 2002, the Iowa Department of Public Health will continue this work under a new 4-year Robert Wood Johnson Covering Kids and Families grant.

Mass Media Campaign

During the spring of 2001, a short-term mass media campaign was used. Television commercials that had been produced for the national Insure Kids Now effort were used. Commercials were aired in both English and Spanish. Also a 60-second radio commercial in English and Spanish was produced. The commercials were aired for a seven-week period during March, April and May. There was an immediate response to the media campaign. During the six-month period prior to the campaign, the ***hawk-i*** customer service center received an average of 400 application requests per month. During the three months in which the commercials aired, application requests averaged 1,500 per month.

Other Media

Ads have been placed in the Qwest Dex directory, in the yellow pages as well as the internet listing ***hawk-i*** 's toll free number. Ads have also occurred in various local and state newsletters, magazines, and other publications.

Partnering with Schools

The Department of Human Services and the Department of Education collaborated to develop an interagency agreement that allowed schools and child care providers who participate in the Free and Reduced Meals Program to make referrals to the ***hawk-i*** Program for outreach purposes. Under this initiative, the names of applicants for the Free and Reduced Meals Program are referred to the ***hawk-i*** Program unless the family specifically asks not to be referred. Participating schools submitted a list of names to the ***hawk-i*** customer service center and then the customer service center mailed an application and information to the families. During the first year of this effort, applications were mailed to approximately 6,000 families. The Departments are working together to ensure this will be an ongoing effort.

Literacy Project

Iowa was one of seven states selected to participate in a literacy project being conducted by the Centers for Medicare and Medicaid Services. The purpose of the project was to evaluate applications, brochures and other state-produced materials to assess how they could be modified to ensure comprehension by persons with very low literacy levels. Additionally, materials written in non-English languages were evaluated to see if they would meet the needs of the populations for which they were intended. These findings are being utilized in the study to redesign the ***hawk-i*** application and brochure in order to remove as many barriers to enrollment as possible.

Multi-Language Poster

The Department of Human Services introduced a new multi-language ***hawk-i*** poster in October 2001 in order to ensure that the needs of persons with limited English proficiency were being met. The poster provides information about the program in five languages: English, Spanish, Bosnian, Vietnamese, and Laotian. It also informs that translator services are available to assist them applications. The need for translation of information into these specific languages was identified through input of local outreach workers, the Bureau of Refugee Services, and use of AT&T translator lines by the ***hawk-i*** customer service center.

Corporate Involvement

Nationally, there has been a growing interest by large corporations to assist states in promoting their SCHIP Program. Iowa actively takes advantage of these efforts to further promote the program. Some of these efforts in Iowa included:

- Wal-Mart/Pampers
- H&R Block
- The Mar**maxx**

In addition to the outreach activities aimed at enrolling eligible children, the state agencies' existing efforts to promote the use of health care services and continuity of care will also be expanded to include the new Title XXI enrollees. These activities include use of the media, case management, and patient follow-up systems, (especially within the Title V, Title X and Title XX Block Grant Programs, and related programs for children within the Iowa Department of Human Services).

Case management consists of a variety of activities designed to identify an individual patient's psychosocial needs and barriers to obtaining health services (such as enrolling in Medicaid), and assist the patient in meeting those needs and accessing services. Patient follow-up includes a variety of activities designed to ensure that patients comply with the recommendations of their health care provider(s) and continue in the health system.

One example of Iowa's continuing effort to improve the health status of school-aged children, the Project Success Program, coordinates social and health services with parental involvement in 13 designated school sites in the Des Moines school district. Project Success sites, which include seven elementary schools, two middle schools, two high schools, and two alternative high schools, refer potentially eligible Medicaid children for eligibility determination. Additionally, sixteen schools based/linked clinics provide services to school-aged children, their siblings and preschool aged children in the district. The clinics are required to assess income levels and refer those children who appear to be Medicaid eligible for eligibility determination while at the same time providing needed medical services.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. X Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

See Attachment 3 for the benchmark plan.
Effective February 1, 2005, these are the health and dental plans currently participating in the ***hawk-i*** program.

- John Deere Health Plan (See Attachment 4)
- Wellmark Blue Cross Blue Shield of Iowa (See Attachment 6)
- Delta Dental of Iowa (See Attachment 11)

6.1.3. Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If Aexisting comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for a existing comprehensive state-based coverage.

6.1.4. Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. Coverage the same as Medicaid State plan

6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. Coverage that is the same as defined by Aexisting comprehensive state-based coverage.

6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. X Inpatient services **(Section 2110(a)(1))**

6.2.2. X Outpatient services **(Section 2110(a)(2))**

6.2.3. X Physician services **(Section 2110(a)(3))**

6.2.4. X Surgical services **(Section 2110(a)(4))**

6.2.5. X Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. X Prescription drugs **(Section 2110(a)(6))**

6.2.7. Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. X Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. X Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. X Inpatient mental health services, other than services described in 6.2.18, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. X Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. X Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. X Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. X Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. X Dental services **(Section 2110(a)(17))**

6.2.18. X Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. X Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. X Case management services **(Section 2110(a)(20))**

6.2.21. Care coordination services **(Section 2110(a)(21))**

6.2.22. X Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. X Hospice care **(Section 2110(a)(23))**

6.2.24. X Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25. Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. X Medical transportation **(Section 2110(a)(26))**

6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. X The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a)):**

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (**2102(a)(7)(A)) (42CFR 457.495(a))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. X Quality standards
The Department of Human Services (DHS) encourages all contracted managed health plans to pursue National Committee for Quality Assurance (NCQA) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification.

7.1.2. X Performance measurement
Refer to Section 9.1

The ***hawk-i*** Functional Health Assessment Survey
The report presents the results of an ongoing evaluation of the impact of the Healthy and Well Kids in Iowa (***hawk-i***) Program on the access to and health status of enrolled children. The first evaluation, parents' responses to a survey given at the time they joined the program (the baseline survey) are compared with their responses to a survey given after their child has been enrolled for about a year (the follow-up survey) to determine if there are differences in the perceived ability to receive health services or in their child's health status. Also included in the follow-up survey and presented in the report are questions specific to ***hawk-i*** , such as ratings of the private health plans that contract with ***hawk-i*** and the impact of having health insurance.

7.1.3. X Information strategies
All health plans participating in the ***hawk-i*** program are required to provide encounter data in accordance with the provisions outlined in their contract.

Additionally, all health plans are required to provide written information to enrollees which, at a minimum, includes the following:

- the phone number(s) that can be used for assistance to obtain information about emergency care, prior authorization, scheduling appointments, and standard benefit/services information;
- current provider directory;

- hours of service of the plan;
- appeal procedures;
- policies on the use of emergency services
- information on the use of non-participating providers;
- access of after hours care;
- enrollee rights and responsibilities;
- procedures for notifying enrollees of changes in the benefits or delivery of services; and
- procedures for recommending changes in polices and procedures.

7.1.4. X Quality improvement strategies

All health plans participating in the ***hawk-i*** program are required to have quality improvement plans in place, including mechanisms that allow enrollees to provide input as to how the delivery of services and other aspects of the plan could be improved.

The Clinical Advisory Committee meets quarterly to review data, reports and medical audit results. The committee makes recommendations to the ***hawk-i*** Board on program quality standards and improvement strategies. The nine-member committee is comprised of community medical professionals representing pediatricians, family practice, dental, mental health, nutrition and pharmacy.

7.2. Describe the methods used, including monitoring, to assure: (**2102(a)(7)(B)) (42CFR 457.495)**

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

All health plans are contractually required to provide well-baby care, well-child care, well adolescent care and childhood and adolescent immunization services.

All participating health plans send reminder notices to families that their child(ren) is due for immunizations or well child visits. Additionally, newsletters are sent to families educating them about the importance of preventative services.

The ***hawk-i*** Program collects encounter claims data from participating health and dental plans monthly. HEDIS performance measurements for well-child and adolescent care have been selected for results based analysis (see 9.1). Effective July 1, 2005, the Department has a contract with Iowa Foundation for Medical Care to validate the encounter claims data with a medical record review.

hawk-i 's Functional Health Assessment Survey is an excellent tool to evaluate health status of children enrolled in the ***hawk-i*** program.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR §457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

DHS examines access to care through the IFMC contract. Additionally, DHS uses Geographic Information Systems (GIS) maps to examine the distribution of primary care, dental, and mental health providers for each participating health plan at the county level of geography. The map tracks the geographical distribution of providers in comparison to the number of beneficiaries served in a particular coverage area as well as the distance and time to get to the provider. Access standards utilized for the GIS are 30 minutes/30 miles for primary care provider and dental services, 60 minutes/60 miles for specialty services including mental health and substance abuse.

As noted above, health plans are contractually required to include written procedures in the member handbook on accessing emergency services.

Contracted health and dental plans are required to submit complaint/grievance reports to the Department on a quarterly basis. Additionally, assessment surveys ask specific questions about the member's satisfaction with emergency services.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Contractually, health plans are required to ensure patient care that is coordinated and continuous, including at a minimum:

- systems to assure timely and appropriate referrals for Medically Necessary, specialty, secondary and tertiary care including subspecialization for pediatric care as well as health education services for members; and
- systems to assure provision of care in situations requiring treatment for an emergency medical condition, including an education process to help assure that members know where and how to obtain medically necessary care in an emergency.
- systems to assure that the plan shall not limit providers from disclosing all information about services available to the member related to their medical condition irrespective of the plans coverage or provider network.

Iowa House File (HF2517), the bill that created the ***hawk-i*** program, mandated that a Special Needs Committee be established to make recommendations to the board and to the general assembly concerning the provision of health insurance coverage to children with special health care needs under the program. The purpose of the Committee is to address the following:

1) Define the target population of children with special health care needs for the purposes of determining eligibility under the program.
2) Eligibility options for and assessment of children with special health care needs for eligibility.
3) Benefit options for children with special health care needs.
4) The appropriateness and quality of care for children with special health care needs.
5) Coordination of health services provided for children with special health care needs under the program with services provided by other publicly funded programs.

The Special Needs Committee has periodic meetings with contracted health plans to discuss case management services for members with long-term health care needs.

The Functional Health Assessment Survey asks questions related specifically to a child with chronic medical conditions (see 7.1.2).

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

The following language is included in all health plan contracts follows:
"If the Plan has Prior Authorization of health services, in accordance with the medical needs of the patient, the Plan shall complete the Prior authorization within fourteen (14) days after receipt of a request for services. An extension of up to fourteen (14) days may be permitted if the Enrollee requests the extension or if the physician or Plan determines that additional information is needed. "

Section 8. Cost Sharing and Payment (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. X YES
8.1.2. NO**, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: $10 per child per month, with a maximum of $20 per family for families whose countable income is equal to or greater than 150% of the FPL. Premiums are not imposed on Native American, Alaskan Native children regardless of family income. If a family reports a decrease in income anytime during the 12-month eligibility period and the new income is less than 150% of the FPL, the family does not pay a premium for the reminder of the eligibility period.

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments: Families whose countable income is equal to or greater than 150% of the FPL shall be assessed a $25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition. Copayments are not assessed for Native American, Alaskan Native children, regardless of income. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,

2. Serious impairment to bodily functions or,
3. Serious dysfunction of any bodily organ or part.

8.2.4. Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

Cost sharing is described in the Iowa Administrative Rules and in printed materials about the program, including the informational brochure that contains the application form. (See Attachment 7) Additionally, when approved, each family will receive an approval notice that lists their countable income calculation and the amount of cost sharing, if any.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. X Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. X No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 X No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

There are only two forms of cost sharing in the ***hawk-i*** program. In both cases, they apply only to families with income that equals or exceed 150% of FPL.

1. Premiums of $10 ($120 annually) per child per month with a family maximum of $20 ($240) annually; and
2. A $25 copayment for inappropriate use of the emergency room.

At current poverty levels, the family would have to incur the number of inappropriate emergency room visits indicated below to exceed 5%. Health plans will report enrollee ER usage, resulting in a copayment obligation, to the third party administrator. The third party administrator will track the ER copayment to ensure cost sharing does not exceed 5% of the family income. At the point the ER copayment results in cost sharing exceeding 5%, enrollees will be reimbursed for the cost.

It is expected that the health plans will intervene to educate enrollees about the appropriate use of ER services prior to any family utilizing the ER inappropriately in as many instances indicated in the chart.

HH Size	Annual Income at 150% FPL	5%	Premium Maximum		No. of Annual Inappropriate ER Visits
1	$14,355	$ 717.75	$120	($717.75/$25)	29
2	$19,245	$ 962.25	$240	($962.25/$25)	38
3	$24,135	$1,206.75	$240	($1260.75/$25)	48
4	$29,025	$1,451.25	$240	($1451.25/$25)	58
5	$33,915	$1,695.75	$240	($1695.75/$25)	68
6	$38,805	$1,940.25	$240	($1940.25/$25)	78
7	$43,695	$2,184.75	$240	($2184.75/$25)	87
8	$48,585	$2,429.28	$240	($2429.25/$25)	97

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

The brochure that contains the ***hawk-i*** application states that there is no cost sharing for American Indian/Alaskan Native children. At the time the applicant is approved for the ***hawk-i*** program, an approval notice is sent indicating there is no cost sharing. These provisions are also found in the Iowa Administrative Code at 441- 86.8(1).

Applications to the ***hawk-i*** program ask for the race of the children applying. When race is indicated as Native American or Alaska Native, no cost sharing is assessed to American Indian or Alaska Native children, regardless of income.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

When an applicant receives notification that the applicant is eligible to participate in the program and a premium is required, the applicant has ten working days from the notification to pay the premium. No premium shall be assessed for months of coverage prior to, and including the month of decision. If the premium is not received by the tenth working day, the applicant is sent a notice of denial of eligibility. The applicant has the right to appeal this decision.

After the initial month of coverage, the premium is due no later than the last day of the month prior to the month of coverage. Failure to pay the premium by the last day of the month before the month shall result in cancellation from the program and disenrollment from the health plan.

A child may be reinstated once in a 12-month period when the family fails to pay the premium by the last day of the month prior to the month of coverage. However, the reinstatement must occur within the calendar month following the month of nonpayment and the premium must be paid in full prior to reinstatement. Once a child is disenrolled and canceled from the program due to nonpayment of premiums, the family must reapply for coverage.

If a family reports a decrease in income and a premium is no longer required, premiums will no longer be charged beginning with the month following the month of the report of the change.

Any time an adverse action is taken such as disenrollment and cancellation from the program, the enrollee has the right to appeal the decision. The appeal rights and procedures are written on the backside of the notice.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- X State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- X The disenrollment process affords the enrollee an opportunity to show that the enrolleeσ family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**
- X In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- X The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. X No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. X No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. X No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) 42CFR 457.626(a)(1))**

8.8.4. X Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. X No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. X No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Objective One: Increase the health status of children in Iowa.

Objective Two: Increase the number of children who have access to health care.

Objective Three: Appropriate use of medications for children diagnosed with asthma.

Objective Four: Children participating in the Medicaid Expansion and ***hawk-i*** will have access to primary care practitioners.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

Objective One: Increase the health status of children in Iowa.

Medicaid Expansion (M-CHIP) health status goals:

- Health status and health care system measures will show acceptable incremental improvements for the following outcome measurements:

Healthy and Well Kids in Iowa (***hawk-i***) (S-CHIP):
Health status and health care system measures will show acceptable incremental improvements for the following outcome measurements:

1. Fifty percent of the children ages zero to 15 months enrolled in the ***hawk-i*** program will have at least one well-child visit.
2. Eighty percent of the children ages three, four, five and six years old enrolled in the ***hawk-i*** program will have well-child visits.
3. Send each family a health assessment questionnaire to complete for one child in the household. (Refer to Attachment 8).

Objective Two: Increase the number of children who have access to health care.

Medicaid Expansion (M-CHIP)

- Enroll approximately 17,300 total ~~additional~~ children in the Medicaid expansion program.

hawk-i Program (S-CHIP)

- Enroll approximately 31,300 children into health plans participating in the ***hawk-i*** program.

Objective Three: Appropriate use of medications for children diagnosed with asthma.

Medicaid Expansion (M-CHIP)
Sixty-five percent of children enrolled in the Medicaid Expansion program that have a diagnosis of asthma will have long-term control medications.

hawk-i (S-CHIP)
Fifty percent of the children enrolled in the ***hawk-i*** program that have a diagnosis of asthma will have long-term control medications.

Objective Four: Medicaid Expansion (M-CHIP)
Eighty-five percent of the children enrolled in the Medicaid expansion program will have access to a primary care practitioner.

hawk-i (S-CHIP)

Eighty-five percent of the children enrolled in the ***hawk-i*** program will have access to a primary care practitioner.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Assurance of an Objective Means for Measuring Performance

Iowa will measure performance by establishing a baseline for each performance goal through various methods including: conducting a baseline population-based survey; using State vital records, hospital discharge and claims information; and using other Medicaid and non-Medicaid databases that provide relevant information. For each performance goal, the method of measurement will be established and reports will be generated to monitor, on an ongoing basis, Iowa's progress toward meeting the goal.

Objective One: Increase the health status of children in Iowa.

Measurement of Performance:

- Every family approved for the ***hawk-i*** program will be asked to complete a health assessment questionnaire for one child in the household. (Refer to Attachment 8). The State has contracted with the Iowa Foundation for Medical Care to analyze the results of the survey, both at the initial submission and the next review (12 months) when the family is asked to complete the survey on their past 12 month's experience.
- Survey outcomes for ***hawk-i*** include:
  1) Access to care (unmet need) and regular source of medical care,
  2) ER use,
  3) Unmet need and regular source of dental care,
  4) Unmet need for vision care, pharmacy, and behavioral/emotional care,
  5) Receipt of anticipatory guidance
  6) Child's health status
  7) Family environment (e.g., stress)
- Well-child visits in the third, fourth, fifth and sixth years of life will be measured using HEDIS measurements for both the Medicaid Expansion (M-CHIP) and ***hawk-i*** (S-CHIP***)*** programs.

Objective Two: Increase the number of children who have access to health care.

Measurement of Performance:

- Enrollment for the Medicaid expansion and the ***hawk-i*** programs will be measured using monthly enrollment reports.

Objective Three: Appropriate use of medications for children diagnosed with asthma.

Measurement of Performance

Medicaid Expansion (M-CHIP)

- HEDIS measurement set relevant to children and adolescents younger than 21 without modifications.

hawk-i Program (S-CHIP)

- HEDIS measurement set relevant to children and adolescents younger than 19 with modifications.

Objective Four: Children participating in the Medicaid Expansion (M-CHIP) and ***hawk-i*** (S-CHIP) programs will have access to primary care practitioners.

Measurement of Performance

- HEDIS measurements with modifications for both the Medicaid Expansion (M-CHIP) and the ***hawk-i*** (S-CHIP) programs.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. X The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. X The reduction in the percentage of uninsured children.

9.3.3. X The increase in the percentage of children with a usual source of care.

9.3.4. X The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. X HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. X Other child appropriate measurement set. List or describe the set used.

9.3.7. X If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. X Immunizations
- 9.3.7.2. X Well child care
- 9.3.7.3. X Adolescent well visits
- 9.3.7.4. X Satisfaction with care
- 9.3.7.5. X Mental health
- 9.3.7.6. X Dental care
- 9.3.7.7. Other, please list:

9.3.8. X Performance measures for special targeted populations. (asthma and diabetes)

9.4. X The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. X The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

Iowa's SCHIP annual report is completed by January 1 following the end of the Federal fiscal year utilizing the framework template developed by the National Academy for State Health Policy (NASHP).

The March supplement to the Current Population Survey (CPS) is utilized to calculate the baseline number of uncovered low-in children in Iowa.

The State has an approved Section 1915(b) waiver for Primary Care Case Management (PCCM). The State is responsible for assessment and evaluation under the PCCM waiver and intends to use the same investigator and contract for his Medicaid Expansion as used for the PCCM. The investigator (the

Public Policy Center at the University of Iowa) will have access to Medicaid data and can develop measures such as number of office visits, continuity of care, and hospitalizations that would compare the newly enrolled group to the currently existing Medicaid population.

9.6. X The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. X The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. X The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

- 9.8.1. X Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. X Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. X Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. X Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

The initial implementation of ***hawk-i*** included public involvement through an appointed task force, public forums and the creation of the ***hawk-i*** Board (see 1.3). Rural and urban focus groups were also held to obtain input into the application and outreach materials.

There are two venues by which the public can provide input into any changes made in the ***hawk-i*** program:

1) The ***hawk-i*** Board meetings are held monthly and are open to the public. The agenda for the Board meeting is posted on the ***hawk-i*** website prior to the meeting. During each meeting time is allowed for public comment on any changes being proposed or any aspect of the program; or
2) Through the administrative rules process. The Administrative Procedures Act, Iowa Code Chapter 17A, requires all state agencies to promulgate rules for the operation of their programs. The rule-making process increases agencies' accountability to the public, allows public participation in the formulation of rules, and provides legislative oversight for program operations.

Before the Department's rules are adopted, they are published in the Iowa Administrative Bulletin as a "notice of intended action." Any interested people may submit comments on the proposed rules within time frames set forth in the notice. All notices must allow at least 20 days for persons to submit comments or to request an oral presentation.

The Department may not adopt the rules until 35 days after the date the notice of intended action is published. Following notice and adoption, the final rules are again published in the Iowa Administrative Bulletin. They become effective at a date specified with the final rule. Normally the Department must allow at least 35 days from the date of publication for people to prepare to implement the rules.

The ***hawk-i*** Board first approves any proposed changes to the ***hawk-i*** administrative rules during public meetings. The rules then go through the Department's administrative rules process. The ***hawk-i*** Board must then approve the rules for a second time during a public meeting before they are adopted.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR §457.125. **(Section 2107(c)) (42CFR 457.120(c))**

The state will send a copy of any proposed rule for the ***hawk-i*** program to the Native American Tribes for review and comment.

Contracts with local grassroots organizations require that the action plan for local outreach activities must how the contractor will engage the special populations in their area, including but not limited to, Native American tribes for development of the action plan and concurrent activities..

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

See the response for 9.9.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

Planned use of funds, including --
- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

CHIP State Plan Amendment SFY 2006

	State Dollars	Federal Dollars	Total Dollars
Medicaid expansion	$5,663,741	$16,573,172	$22,236,913
hawk-i premium(Net of deductions for cost sharing)	$10,732,409	$31,405,041	$42,137,450
Administrative Costs			
Fiscal agent cost of processing Medicaid claims	$116,862	$341,959	$458,821
Outreach	$127,350	$372,650	$500,000
Administration	$610,821	$1,787,377	$2,398,198
Total CHIP SFY 2006	$17,251,183	$50,480,199	$67,731,382

Administration Percent: 4.96%

Assumptions

Monthly average enrollment - Medicaid expansion	11,216
Monthly average enrollment -Medicaid expansion (MAC) infant	598
Monthly average enrollment - *hawk-i* managed care	12,274
Monthly average enrollment - *hawk-i* indemnity	8,888

	State $	Federal $	Total $
***hawk-i* cost sharing**	($225,663)	($660,334)	($885,997)
This has been deducted against premiums on summary page			

PM/PM Rates

Medicaid expansion	$148.30
Medicaid expansion - (MAC) infants	$317.19
hawk-i managed care	$160.16
hawk-i indemnity	$176.13

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. X The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. X The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. X The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 X The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. X 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. X Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. X Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. X Section 1128A (relating to civil monetary penalties)
- 11.2.5. X Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. X Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR §457.1120.

The Iowa Department of Human Services uses the same appeal process for all of its programs, including Medicaid and ***hawk-i*** eligibility and enrollment. This process is detailed in Attachment 9.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR §457.1120.

The state is using the Statewide Standard Review. Section 514I.2(10) of the Iowa Code requires all participating health plans to be licensed by the Iowa Division of Insurance. All ***hawk-i*** enrollees receive services from health insurance issuers subject to state health insurance law. Managed care organizations are subject to Iowa Code Chapter 514B and indemnity health insurance carriers are subject to Iowa Code Chapters 505, 514. All health services are subject to an external review as described in Iowa Code Chapter 514J.

See Attachment 10.

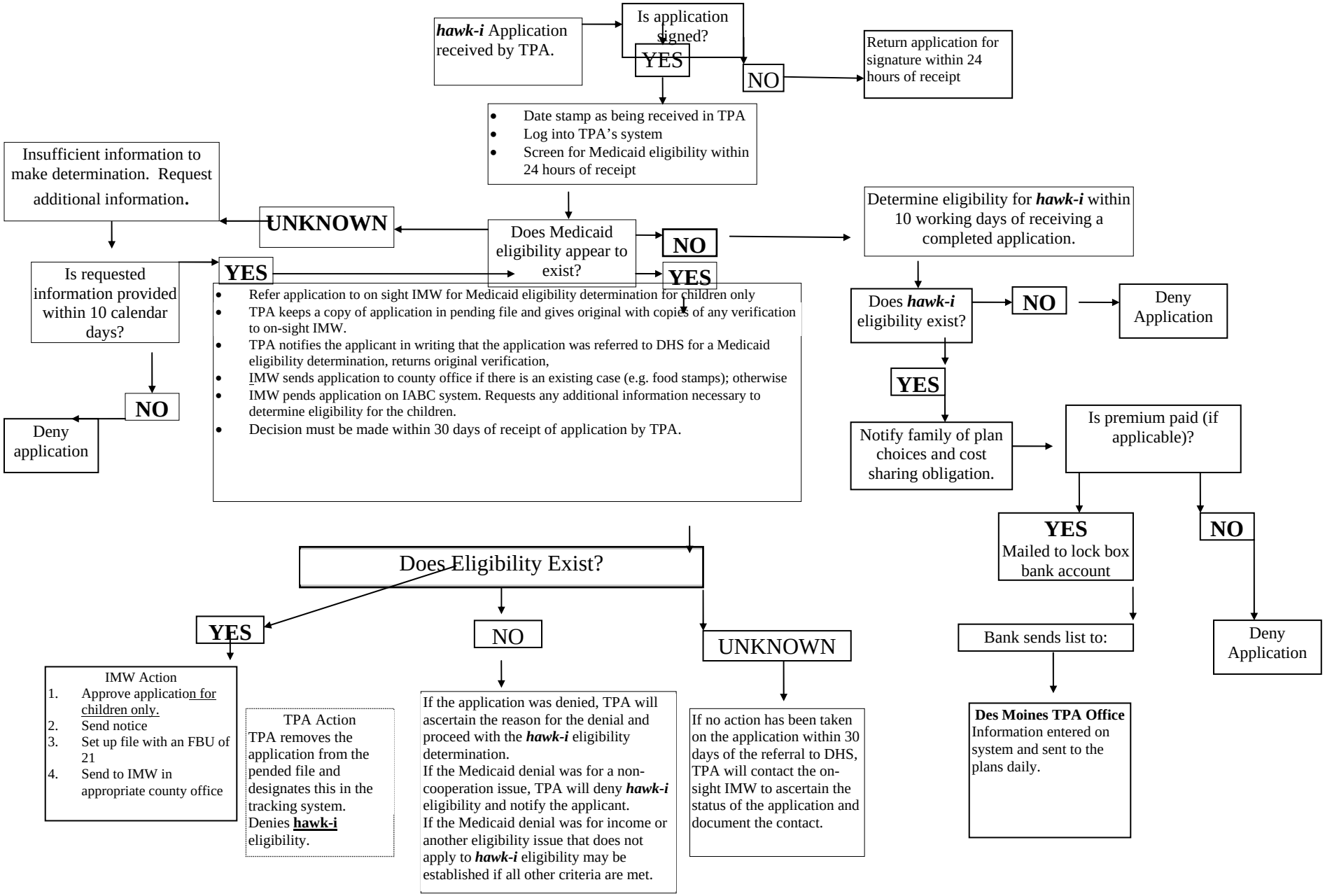
Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR §457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

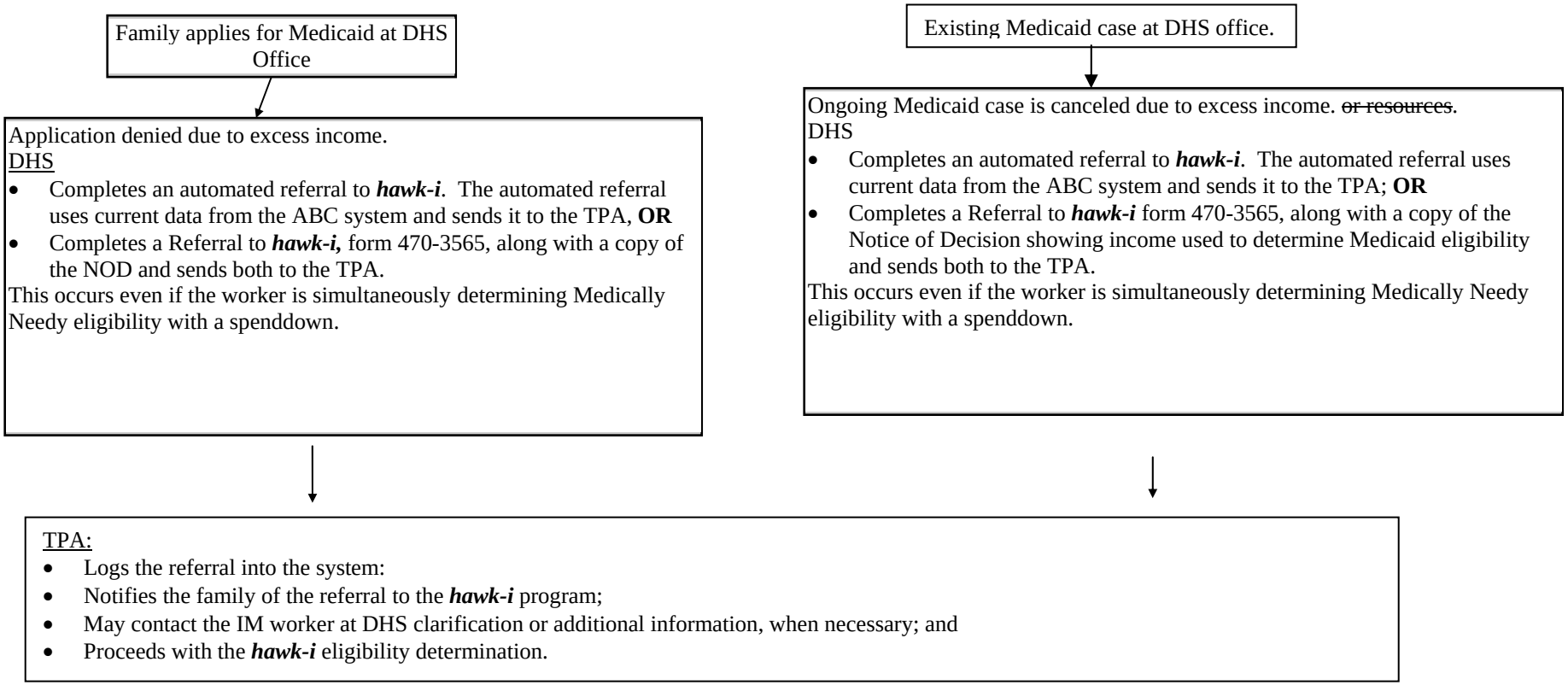
Attachment 2

Referral Process

Enrollment Process for ***hawk-i***



Referral Process from DHS to *hawk-i*



Iowa Department of Human Services

REFERRAL TO THE *hawk-i* PROGRAM

☐ Denied Application/Individual (provide Medicaid application date) ☐ Canceled Case/Individual

Date:		Case Name:	
Worker Name:	Worker Number:	Case Number:	
Worker County:	Worker Phone:	Case Phone:	County of Residence:

People in Household	Social Security Number	Birth Date	Sex	Citizen (If No, explain alien status in Comments)	How Related to Case Name (spouse, parent, child, etc.)	Medicaid End Date (only on canceled cases or individuals)	Language Preference	If child, do they have health insurance coverage?
1.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
2.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
3.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
4.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
5.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
6.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
7.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No

This case is being referred to *hawk-i* because:

☐ The children must meet a spenddown under the Medically Needy program.

☐ The following children have been voluntarily excluded from the Medicaid eligible group because the **child's income** creates Medicaid ineligibility for the remaining household members. ***Indicate the income of the voluntarily excluded child below in the next section. Also, attach an NOD showing the Medicaid eligibility calculation for the other family members.*** (**Note:** Children voluntarily excluded for non-financial reasons are not eligible for ***hawk-i***.)

1. 2.

3. 4.

Income

☐ Family members are employed at the following companies:

☐ Family members have unearned income from the following sources:

This case has (check all that apply):

☐ Non-recurring lump sum Income:

Amount prorated monthly (Standard of Need): $

Last month and year of period of proration: (MM/YYYY)

☐ Self-employment income:

Amount of depreciation (from Schedule C or F): $
(or attach a copy of Schedule C or F)

☐ Unemployment benefits:

Name of person(s) receiving UIB:

☐ Income of voluntarily excluded child:

$ per (week, month, etc)

☐ Income has been verified (attach verification to referral)

☐ Income has not been verified

Attachments: ☐ Copy of Notice of Decision showing Medicaid ineligibility (**Required**)

Comments

REMINDER – Only Refer Children Who Are Over Income For Medicaid

Do Not Refer Children to the *hawk-i* Program Who:

- Are age 19 or older; **or**
- Are ineligible for Medicaid due to a non-cooperation issue.

Send via local mail to:

Department of Human Services
Attn: MAXIMUS/***hawk-i*** Program
Division of Financial, Health and Work Supports
Hoover State Office Building, 5th Floor
1305 E. Walnut
Des Moines, IA 50319-0114 **OR** **Fax**: 515-457-7701

hawk-i Referral Process
A Desk Guide for Income Maintenance Workers

Policy: Refer children under age 19 to the ***hawk-i*** program when any child for whom a family is applying is over income for Medicaid or is conditionally eligible for MN. (Employees' Manual Chapters 8-B & 8-G)

Making a Referral:

Referring a Denied Application	Referring a Cancelled Case
To refer an application that has been denied or an application that has been approved only for MN with a spenddown: ❑ Fill out the referral form* and send it to ***hawk-i*** with copies of: 1. the Medicaid application 2. the income verification 3. the notice of decision ❑ Make the referral within one working day from the time that you know that the child is not eligible for Medicaid or that they must meet a spenddown under Medically Needy. ❑ The Medicaid application date will become the ***hawk-i*** filing date.	To refer a case that has been cancelled or must now meet a spenddown under MN: ❑ Fill out the referral form* and send it to ***hawk-i*** with copies of: 1. the income verification 2. the notice of decision ❑ Make the referral within one working day from the time that you know that the child is not eligible for Medicaid or that they must meet a spenddown under Medically Needy. ❑ If eligible, there will be no break in coverage for children moving from Medicaid to ***hawk-i.***
The family does not have to fill out a separate ***hawk-i*** application.	

* "Referral to the Healthy and Well Kids in Iowa (***hawk-i***) Program," form 470-3565, is available in State Approved Forms on Outlook.

Send the referral and accompanying verification to: (Do not send case records or original application forms)

Interoffice Mail: Department of Human Services **OR** **FAX:** 515-457-7701

Attn: MAXIMUS/***hawk-i*** Program
Division of Medical Services – 5th Floor
1305 E. Walnut
Des Moines, IA 50319-0114

*Questions? Call **hawk-i** Customer Service: 1-800-257-8563*

OVER

Helpful Hints:

- If a case goes over income because of a lump sum period of proration, but the children would otherwise be Medicaid eligible, note in the comments section of the referral form that there is a lump sum, how much it is, and when the period of proration ends.

- If a child is voluntarily excluded from Medicaid because of the child's income, refer the child to ***hawk-i***. Note in the upper right corner of the back page of the referral that the child is excluded and include their income information.

- Do not refer children to ***hawk-i*** if the child has been voluntarily excluded from Medicaid for reasons other than the child's income.

- Do not refer children to ***hawk-i*** when the reason they are not eligible for Medicaid is due to non-cooperation (e.g. failure to return review forms, failure to provide verification, etc.).

- Self-employment: ***hawk-i*** allows a deduction for depreciation of capital assets for self-employment while Medicaid does not. In this situation, include the appropriate Schedule C or F when making the referral.

- Unemployment: Medicaid looks at unemployment as a weekly benefit. ***hawk-i*** looks at the maximum benefit the person can receive and uses it to project income for the 12-month enrollment period. Include the DBRO screen front page (from IWD system) when referring these cases to ***hawk-i***. Indicate in the comments section if there is any other unearned income on the NOD so it gets used.

- When you make a referral and give the family a ***hawk-i*** brochure for informational purposes, take the application out of the brochure so they don't think they have to apply separately. This will help avoid duplicate applications being filed.

hawk-i Customer Service: 1-800-257-8563
(TDD: 1-888-422-2319)
www.hawk-i.org

Attachment 10

Plan Appeal and Grievance Procedures

Plan Appeals and Grievance procedures

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield	Delta Dental of Iowa
Definition	Any questions, concerns and/or problems regarding coverage and benefits.	Any questions or concerns regarding coverage decisions, preauthorization decisions, or any action concerning the provision of health care services, or other matters concerning the operations of health plan.	Denial of benefits, or disagreement with decision to reduce benefits, or complaint regarding a claim, provider or service provided by Wellmark	Denial or partial denial, or a complaint regarding a claim.
Who can file a complaint or an appeal	A member, a primary care physician (PCP), attending physician or hospital.	An Enrollee's physician, family member or other individual may act as the Enrollee's representative to assist in filing a complaint on behalf of the Enrollee.	Enrollee or someone appointed by the Enrollee	The Enrollee, a representative of the Enrollee, or the dentist.
Type of appeal				
Informal	(First level of appeal for IHS) Member contacts Member Services with question, concern or problem.	Enrollee contacts Customer Service Department or other health plan employee with an inquiry.	Enrollee calls Customer Service Department	Enrollee calls Customer Service Department
➢ **Decision maker**	Member Services.	Customer service department. If Enrollee is dissatisfied with the response, the enrollee must always be advised of next step in complaint process.	Customer service department researches and resolve issue and notify Enrollee of right to appeal if appropriate	Customer Service Department. If Enrollee disagrees with the decision, enrollee can receive a full and fair review.
Standard or First Level Appeal Process	(Second level of appeal for IHS) If not satisfied with answer received from first level of appeal, may submit a request for a second level appeal. Needs to be in writing.	Used for all cases that are not life threatening or severe enough to seriously jeopardize the member's health and/or ability to regain maximum function. Written expression of dissatisfaction with health plan requesting that a decision be overturned.	If enrollee is not satisfied with resolution of a complaint, enrollee may contact customer service department by phone or submit a written appeal by completing an Enrollee Appeal Form.	The enrollee may submit a written request of review and appeal. The written request should have the reason for the request, documents, records and any other information related to the claim.

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield	Delta Dental of Iowa
➢ **Time frames for filing an appeal**	No later than 30 working days after the date of the action, decision or incident occurred with which the person is unhappy.	Complaint form shall be filed within 90 days from date the problem in question occurred. The form shall be signed and the facts listed.	The Enrollee Appeal Form must be filed within 120 days of the complaint decision.	The written request should be submitted within 180 days from the notice of denial.
➢ **Decision maker**	Iowa Health Solutions Grievance Committee	Health plan's medical director or physician advisor when medical review is needed or appropriate. When the issue requires an administrative the appropriate department makes the decision. Persons involved in the initial determination may not review the appeal.	Wellmark Blue Cross and Blue Shield Enrollee Appeal Committee	Delta Dental Appeal Committee.
➢ **Time frame for decision**	Within in 15 days of receiving grievance for medial services. All other types of grievances will be made within 30 days of receipt of grievance.	Within 30 calendar days of receipt of complaint with details of the decisions and further appeal process available to Enrollee, should decision not be in Enrollee's favor. The written decision may be extended by ten business days to obtain documentation records necessary to resolve the case and the delay is in the interest of the Enrollee.	30 calendar days from receipt of form, if no additional information is needed. If additional information is not received in time allowed, Wellmark will make a decision.	Within 30 days of receiving the request.
➢ **Notification of decision**	Letter will be made stating the Committee's decision and the reason for the decision.	Written letter to all parties involved.	Written letter to all parties involved. .	Written letter to all parties involved.
Expedited Appeal	May be requested for any denial of utilization management and there is an urgent situation.	Requested to accommodate the urgency of the situation when the standard appeal process will cause delay in the rendering of health care that would be life threatening or severe enough to seriously jeopardize the member's health and/or ability to regain maximum function.	May be requested anytime there is denial in utilization management and the situation is urgent.	May be requested if the situation is urgent.

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield	Delta Dental of Iowa
➢ **Who can file a complaint or an appeal**	Member, pcp, attending physician or hospital	Enrollee or physician contacts JDHP verbally or in writing with request for expedited appeal. An enrollee's physician, family member or other individual may act as the Enrollee's representative to assist in filing an appeal on behalf of the Enrollee.	Enrollee, physician or hospital	The Enrollee, a representative of the Enrollee, or the dentist.
➢ **Decision Maker**	Medical director or physician advisor	Medical director or physician advisor	Medical director or physician advisor	Dental director or dental consultant.
➢ **Time frame for decision to be made**	Within 72 hours of request	Every attempt will be made to provide a decision for expedited appeals that are emergent in nature within 24 hour turnaround of receipt of complete medical information necessary to render a decision.	Within 72 hours of request	Every attempt is made to provide a decision as quickly as possible.
➢ **Notification of decision**	By phone or fax, followed by written decision.	The Enrollee will be informed of the decision by telephone or fax within 72 hours. In addition, a written decision is issued within 2 business days detailing the decision. If ruling is not in favor of the Enrollee, the Enrollee has 14 days to appeal the decision orally or in writing.	By phone or fax, followed by written decision.	By phone or fax, followed by a written decision.
Second Level Appeal	(3rd level appeal for IHS) If member, pcp, attending physician or hospital is not satisfied with answer from 2nd level appeal	An appeal to Grievance Committee is a further request from an Enrollee than an unfavorable Level 1 complaint decision be reversed.	If not satisfied with the resolution of first level appeal, Enrollee may appeal to the Enrollee Appeal Committee of the Board.	A second request may be made if not satisfied with appeal decision.

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield	Delta Dental of Iowa
➢ **Time frame to file a second level appeal**	In writing within 15 days of decision of the second level appeal.	If the Enrollee is not satisfied with the outcome of the decision he/she has 14 days from the date the decision was issued in which to file a formal appeal to the Enrollee Grievance Committee of JDHP.	Must be filed within 30 calendar days of receipt of decision	Must be filed within 30 days of receipt of the decision.
➢ **Decision maker**	Iowa Health Solution's Physician Advisory Group.	The Grievance Committee. Grievances will not be heard or voted upon unless at least 50% of the voting individuals of the committee are Enrollees who are consumers. The Grievance Committee shall have authority to resolve by majority vote grievances filed by Enrollees. The panel will include participants who were not involved in the previous decisions. A physician who was not previously involved will review the case when it involves a denial of services or treatment based on medical necessity. At least one practitioner in the same or similar specialty that typically manages the medical condition, procedure or treatment must be involved in the review at one level of the appeal process.	Enrollee Appeal Committee of the Board	Dental director or dental consultant.
➢ **Time for decision to be made**	Within 30 days of receipt of the second level appeal	Grievance Committee Hearing should be held within 45 days of the receipt of the appeal letter. An additional 30 day extension is avialable due to a delay in obtaining documents necessary for the Grievance Committee to make a deterimination.	The Enrollee Appeal Committee of the Board will meet within 30 working days of receiving the appeal. The Enrollee Appeal Committee of the Board will issue a final decision and notify the Enrollee by letter within five business days of the meeting.	Within 30 days from the date of receipt of the second request.

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield	Delta Dental of Iowa
➢ **Hearing notice information**	A member may attend the meeting with the Grievance Committee or Physician's Advisory Group. This can be in person or via teleconference.	The Enrollee shall be notified, at the time of the hearing, of the name and affiliation of the Enrollee Grievance Committee members. JDHP shall not present any evidence without the Enrollee having been given the opportunity to be present. Each party may present his or her case as to why the decision rendered should be sustained or rejected. The Enrollee shall have the right upon written request to review all documents. The Enrollee may submit issues and comments in writing.	The Enrollee or someone acting on behalf of the enrollee may participate in the meeting of the Enrollee Appeal Committee of the Board. The Enrollee will receive a letter within five working days or receipt of appeal, acknowledging the receipt of the second level appeal and the date of the appeal meeting.	NA
➢ **Notification of decision**	Letter will be mailed stating the Group's decision and the reason for the decision.	Final disposition letter detailing the reasoning of the decision, is mailed to the Enrollee within five business days after final decision by the Grievance Committee. The letter notifies the member of any further appeal rights they may have.	A written decision is sent to all parties.	A written decision is sent to all parties.
External Review	(Fourth level of appeal for IHS) If not satisfied with answer of third level appeal, a fourth and final appeal can be made to the Department of Insurance. The fourth level of appeal must be submitted in writing within 15 days of the decision of the third level appeal.	JDHP shall not preclude the Enrollee from filing a complaint with the Department of Insurance nor shall it preclude the Department of Insurance from investigating a complaint persusant to its authority under section 4-6 of The HMO Act.	If the Enrollee has exhausted the Plan's appeal process regarding a denial of benefits based on medical necessity, the Enrollee or the provider acting on behalf of the Enrollee may request a decision of the Wellmark's decision with the Iowa Insurance Commissioner. This request must be filed in writing no later than 60 days following Wellmark's decision.	May appeal to the Iowa Insurance Commissioner.

	Iowa Health Solutions	John Deere Health Plan	Wellmark Blue Cross Blue Shield	Delta Dental of Iowa
Other review	NA	If a member is dissatisfied with the decision of the Member Grievance Committee, he or she may file a request for arbitration with JDHP in writing within six months of the date of the decision. Arbitration shall be conducted in accordance with the Rules of the American Health Lawyers Association Alternative Dispute Resolution Service. The parties waive their right to jury trial, except for enforcement of the decision of the arbitrator.	NA	NA

Attachment 11

Delta Dental of Iowa